MICHAEL E. BUXBAUM, D.O. P.A.
NEW PATIENT MEDICAL HISTORY

NAME: **DATE OF BIRTH:** **DATE:**

SEX
□ M □ F

MARITAL STATUS
□ S □ M □ W □ D □ SEP

PREGNANCY HISTORY *Enter the number of:*
Times pregnant___ Miscarriages_____ Living children___

ALLERGIES to medications: □ None □ Penicillin □ Sulfa □ Codeine □ Other_____

LIST ALL MEDICATIONS YOU ARE NOW TAKING

1.	**5.**	**9.**
2.	**6.**	**10.**
3.	**7.**	**11.**
4.	**8.**	**12.**

LIST ALL PRIOR HOSPITALIZATIONS AND SURGERIES

1.	**4.**
2.	**5.**
3.	**6.**

PERSONAL AND FAMILY ILLNESS

Check where you or members of your family have had the following illnesses or problems:

You	Your Family		You	Your Family	
□	□	Alcoholism	□	□	Liver Disease / Hepatitis / Yellow jaundice
□	□	Anemia	□	□	Lung Disease / Emphysema / Chronic Bronchitis
□	□	Asthma	□	□	Mumps, Measles / Chicken Pox
□	□	Cancer / Tumor	□	□	Nervous Breakdown / Mental illness
□	□	Diabetes	□	□	Phlebitis / Vasculitis / Blood clots
□	□	Drug Use/Abuse	□	□	Reflux / Gastritis
□	□	Depression/anxiety	□	□	Rubella / German measles
□	□	Eczema / hives / rashes	□	□	Stroke
□	□	Epilepsy/seizures	□	□	Suicide attempt
□	□	Eye problems	□	□	Thyroid disease
□	□	Glaucoma	□	□	Ulcer in stomach / duodenum
□	□	Heart disease	□	□	Congestive Heart Failure
□	□	High blood Pressure	□	□	HIV + / AIDS
□	□	Kidney / Bladder problems	□	□	Heart Attack

HEALTH MAINTENANCE

Vaccine	Year of Last	Test / Exam	Year of Last
Tetanus / Td		Rectal / Stool	
Influenza (FLU)		PAP / Pelvic	
Pneumonia		Mammogram	
Hepatitis		Cholesterol	
Tuberculosis		Eye	

TOBACCO/ALCOHOL/DRUGS

Do you smoke? ___Yes ___No How many packs a day? _____ How many years? _____
Do you drink alcohol? ___Yes ___No ___Socially ___Moderately ___Excessively
Do you use any street drugs? ___Yes ___No ___I did in the past Type_____